No. 17-1484

IN THE

Supreme Court of the United States

ALEX M. AZAR, II, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

ALLINA HEALTH SERVICES, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

BRIEF OF FOURTEEN STATE AND REGIONAL HOSPITAL ASSOCIATIONS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

CHAD GOLDER
Counsel of Record
MUNGER, TOLLES & OLSON LLP
1155 F Street NW, 7th Floor
Washington, DC 20004
(202) 220-1107
chad.golder@mto.com

J. MAX ROSEN
MUNGER, TOLLES & OLSON LLP
560 Mission Street, 7th Floor
San Francisco, CA 94105
(415) 512-4000
max.rosen@mto.com

TABLE OF CONTENTS

Page

INTEREST OF *AMICI CURIAE* 1

INTRODUCTION AND SUMMARY OF THE ARGUMENT 8

ARGUMENT 13

I. CONGRESS CREATED THE DSH PROGRAM TO ASSIST HOSPITALS IN TREATING LOW-INCOME PATIENTS 13

A. Congress Created the Medicare DSH Program Both to Reimburse Hospitals for Caring for Low-income Patients, and to Ensure Such Hospitals Survive to Support Their Communities 13

B. DSH Payments Remain a Necessary Source of Funding for Hospitals Treating Low-income Patients 16

II. NOTICE-AND-COMMENT IS VITAL TO THE SUCCESS OF THE DSH PROGRAM 23

CONCLUSION 33

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Allina Health Servs. v. Burwell,
201 F. Supp. 3d 94 (D.D.C. 2016) 14

Allina Health Servs. v. Price,
863 F.3d 937 (D.C. Cir. 2017) 9, 14, 31

Allina Health Servs. v. Sebelius,
746 F.3d 1102 (D.C. Cir. 2014) 32

Am. Hosp. Ass'n v. Bowen,
834 F.2d 1037 (D.C. Cir. 1987) 27

Ass'n of Irritated Residents v. EPA,
494 F.3d 1027 (D.C. Cir. 2007) 24, 26

Batterton v. Marshall,
648 F.2d 694 (D.C. Cir. 1980) 24

Chocolate Mfrs. Ass'n of U.S. v. Block,
755 F.2d 1098 (4th Cir. 1985) 24

Northeast Hosp. Corp. v. Sebelius,
657 F.3d 1 (D.C. Cir. 2011) 9

FEDERAL STATUTES

42 U.S.C. § 1395ww(d)(5)(F) 8, 14

TABLE OF AUTHORITIES
(continued)

Page(s)

LEGISLATIVE MATERIALS

Att'y Gen.'s Comm. on Admin. Procedure, Administrative Procedure in Government Agencies, S. Doc. No. 77-8 (1st Sess. 1941) 26

OTHER AUTHORITIES

Richard K. Berg, *Re-examining Policy Procedures: The Choice between Rulemaking and Adjudication*, 38 Admin. L. Rev. 149 (1986) 27

Felicien "Fish" Brown, *Health Policy – DSH Hospitals: Still Caring for the Poor*, Journal of the Catholic Health Association of the United States (Jan-Feb. 1999), available at https://www.chausa.org/publications/health-progress/article/january-february-1999/health-policy-dsh-hospitals-still-caring-for-the-poor ..... passim

Robyn Whipple Diaz, *Unequal Access: The Crisis of Health Care Inequality for Low-Income African-American Residents of the District of Columbia*, 7 J. Health Care L. & Policy 120 (2004) ..... passim

TABLE OF AUTHORITIES
(continued)

Page(s)

Disproportionate Share Hospital (DSH), CMS.gov, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html (last accessed Dec. 11, 2018) 14

Debra A. Draper, et al., *Community Report: Financial Pressures Continue to Plague Hospitals*, Health System Change (Summer 2001), available at http://www.hschange.org/CONTENT/359/#jump1 ..... 21, 28

Lynne Fagnani and Jennifer Tolbert, *The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Program,* National Association of Public Hospitals & Health Systems (Nov. 1999), available at https://collections.nlm.nih.gov/catalog/ nlm:nlmuid-100927939-pdf ..... passim

Craig B. Garner, *Medicare: The Perpetual Balance Between Performance and Preservation*, 30 J. Contemp. Health L. & Policy 279 (2014) 23

TABLE OF AUTHORITIES
(continued)

Page(s)

Ariel Hart & Tamar Hallerman, *Grady, Georgia Hospitals Stand to Lose Millions in Federal Payments*, The Atlanta Journal-Constitution, Aug. 5, 2017, available at https://www.myajc.com/news/state-ampampamp-regional/grady-georgia-hospitals-stand-lose-millions-federal-payments/cLZvuPw5flFUuehW1c292H/ 16

Health Policy Institute, *Rural and Urban Health, Data Profile Number*, Georgetown University (Jan. 2003), available at https://hpi.georgetown.edu/agingsociety/pubhtml/rural/rural.html 19

Renee Y. Hsia, et al. *A US National Study of the Association Between Income and Ambulance Response Time in Cardiac Arrest*, JAMA Network (Nov. 30, 2018), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2716993 22

Key Facts About the Uninsured Population, Kaiser Family Foundation (Dec. 07, 2018), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population// 19

TABLE OF AUTHORITIES
(continued)

Page(s)

Jeffrey S. Lubbers, *A Guide to Federal Agency Rulemaking* (5th Ed. 2012) 24, 27, 29

Les Masterson, *Health Affairs: Ending Medicaid Expansion Would Cause Rural Hospitals to go Under* (Jan. 9, 2018), https://www.healthcaredive.com/news/health-affairs-ending-medicaid-expansion-would-cause-rural-hospitals-to-go/514307/..... 18, 22

Medicaid Disproportionate Share Hospital (DSH) Payments, Medicaid.gov, https://www.medicaid.gov/medicaid/finance/dsh/index.html (last visited Dec. 11, 2018)..... 15

David Moyse, *Urban Legend: Dispelling the Myth That Rural Hospitals Require Increased Federal Funding at the Expense of Urban Hospitals*, 22 J. Contemp. Health L. & Policy 210 (2005) 21, 22, 28

TABLE OF AUTHORITIES
(continued)

Page(s)

Jack O'Brien, *After Individual Mandate Repeal, Who'll Pay for Rise in Uncompensated Care*, *Health*Leaders (Dec. 20, 2017), https://www.healthleadersmedia.com/finance/after-individual-mandate-repeal-who%E2%80%99ll-pay-rise-uncompensated-care 20

Michael Ollove, *'Safety Net' Hospitals Face Federal Budget Cuts*, Pew (Jan. 16, 2018), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/01/16/safety-net-hospitals-face-federal-budget-cuts 18, 21, 28, 29

Richard J. Pierce, Jr., 1 *Administrative Law Treatise* (5th Ed. 2010) 24, 26, 27, 32

Richard J. Pierce, Jr., *Distinguishing Legislative Rules from Interpretative Rules*, 52 Admin. L. Rev. 547 (2000) ..... passim

Caitlin Podbielski, *Piling It on DSH Providers' Plate: Why PPACA's Eyes Are Bigger Than Its Stomach*, 20 Annals Health L. Advance Directive 144 (2011) 16, 17, 20, 30

TABLE OF AUTHORITIES
(continued)

Page(s)

Lisa Rab, *Rural Hospitals Are Dying and Pregnant Women Are Paying the Price*, Politico (Oct. 3, 2017), https://www.politico.com/magazine/story/2017/10/03/meadows-medicaid-rural-hospitals-pregnant-women-dying-215671 ..... passim

Glen O. Robinson & Ernest Gellhorn, *The Administrative Process* (1974) 26, 29

Brittany Ruess, *Rural Hospitals on Life Support in Missouri*, Columbia Daily Tribune, Sept. 30, 2017, available at https://www.columbiatribune.com/news/20170930/rural-hospitals-on-life-support-in-missouri 17, 18

Eugene Scalia, *The Value of Public Participation in Rulemaking*, The Regulatory Review (Sept. 25, 2017), available at https://www.theregreview.org/2017/09/25/ scalia-public-participation-rulemaking/ 27

Michael Spivey & Arthur L. Kellerman, *Rescuing the Safety Net*, 360 New Engl. J. Med. 2598 (June 18, 2009), available at https://www.nejm.org/doi/10.1056/NEJMp 0900728 ..... 16, 17, 22

TABLE OF AUTHORITIES
(continued)

Page(s)

Adrienne St. Clair, *Rethinking Rural Health Solutions to Save Patients and Communities* (Feb. 28, 2018), https://www.npr.org/ sections/health-shots/2018/02/28/588826085/rethinking-rural-health-solutions-to-save-patients-and-communities 18, 19

Debby Warren, *Rural Hospitals Face Growing Financial Trouble, Says Moody's*, Nonprofit Quarterly (Sept. 11, 2018), https://nonprofitquarterly.org/2018/09/11/rural-hospitals-face-growing-financial-trouble-says-moodys/ 18, 23

Jane Wishner, et al, *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies,* Kaiser Family Foundation (July 7, 2016), available at https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/ .....passim

INTEREST OF *AMICI CURIAE*[1]

The fourteen state and regional hospital associations described below respectfully submit this brief as *amici curiae*.

Amici's member hospitals and hospital systems are directly affected by changes to Medicare's "Disproportionate Share Hospital" program ("DSH"). Given their members' unique position on the front lines of low-income medical care, *amici* submit this brief to provide the Court with relevant information and guidance on two issues at the heart of this case: *first*, the purpose and importance of the DSH program to hospitals and low-income patients; and *second*, why notice-and-comment procedures are of particular significance in formulating rules that could have a material impact on the DSH program.

The Arkansas Hospital Association (ArHA) is a trade association representing over 100 hospitals and related institutions and the more than 41,000 individuals employed by these organizations across the state of Arkansas. The ArHA is committed to improving the health of Arkansans through the delivery of high quality, efficient, and accessible health care for all. Serving a diverse population in a predominantly rural state, 37 Arkansas hospitals depend on the DSH program to ensure that they can

---

[1] Counsel for all parties have consented to the filing of this brief. In accordance with Rule 37.6, *amici* confirm that no party or counsel for any party authored this brief in whole or in part, and that no person other than *amici* or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

continue to provide and expand access to health care services to Arkansans, allowing them to receive the care they need close to home.

The California Hospital Association (CHA) is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the general acute care and acute psychiatric patient beds in California. CHA's members include all types of hospitals and health systems: non-profit; children's hospitals; those owned by various public entities; as well as investor-owned. CHA provides its members with state and federal representation in the legislative, judicial, and regulatory arenas in an effort to support and assist California hospitals in meeting their legal and fiduciary responsibilities; improve health care quality, access, and coverage; promote health care reform and integration of services; achieve adequate health care funding; improve and update laws and regulations impacting hospitals and health systems; and maintain the public trust in healthcare. As part of this, CHA often participates as an *amicus curiae* in appeals that have a substantial impact on hospitals and health systems. Two hundred forty-four (244) DSH hospitals are members of CHA.

The Georgia Hospital Association is a non-profit trade association made up of member hospitals and individuals in administrative and decision-making positions within those institutions. Founded in 1929, the Association serves 167 hospitals in Georgia. Ninety-two (92) of those hospitals receive DSH funding. The Association's purpose is to promote the health and welfare of the public through the

development of better hospital care for all of Georgia's citizens. The Association represents its members in legislative matters, as well as in filing *amicus curiae* briefs on matters of great gravity and importance to both the public and to health care providers serving Georgia citizens.

The Healthcare Association of New York State (HANYS) is New York's statewide hospital and health system association representing over 500 not-for-profit and public hospitals and hospital based skilled nursing facilities, home health agencies, and hospices. HANYS' members range from rural Critical Access Hospitals to large, urban Academic Medical Centers and other Medicaid and safety net providers. HANYS seeks to advance the health of individuals and communities by providing leadership, representation, and service to health providers and systems across the entire continuum of care. One hundred twenty-eight (128) of HANYS' members receive DSH funding.

The Greater New York Hospital Association (GNYHA) is a Section 501(c)(6) organization that represents the interests of approximately 140 Medicare providers located in New York, New Jersey, Connecticut, and Rhode Island, all of which are not-for-profit, charitable organizations or publicly-sponsored institutions. The vast majority of these hospitals and health systems receive DSH funding. GNYHA engages in advocacy, education, research, and extensive analysis of health care finance and reimbursement policy.

The Illinois Health and Hospital Association (IHA) is a statewide not-for-profit association with a membership of over 200 hospitals and nearly 50 health systems. For over 90 years, the IHA has served as a representative and advocate for its members, addressing the social, economic, political, and legal issues affecting the delivery of high-quality health care in Illinois. As the representative of virtually every hospital in the state, the IHA has a profound interest in this case. The IHA respectfully offers this *amicus curiae* brief in hopes of providing information not addressed by the litigants that will help the Court evaluate the litigants' arguments more thoroughly. One hundred thirteen (113) of IHA's member hospitals receive DSH funding.

The Massachusetts Health and Hospital Association (MassHA) is a voluntary, not-for-profit organization composed of hospitals and health systems, related providers, and other members with a common interest in promoting the good health of the people of the Commonwealth of Massachusetts. Through leadership in public advocacy, education, and information, MassHA represents and advocates for the collective interests of hospitals and health care providers, and it supports their efforts to provide high-quality, cost-effective, and accessible care.

Michigan Health & Hospital Association (MichHA) is the statewide leader representing all community hospitals in Michigan. Established in 1919, the MichHA represents the interests of its member hospitals and health systems in both the legislative and regulatory arenas on key issues and supports their efforts to provide quality, cost-

effective, and accessible care. Seventy-one (71) of MichHA's member hospitals receive DSH funding.

The New Jersey Hospital Association (NJHA) has served as New Jersey's premier health care association since its inception in 1918. NJHA currently has members across the health care continuum including hospitals, health systems, nursing homes, home health, hospice, and assisted living, all of which unite through NJHA to promote their common interests in providing quality, accessible, and affordable health care in New Jersey. In furtherance of this mission, NJHA undertakes research and health care policy development initiatives, fosters public understanding of health care issues, and implements pilot programs designed to improve clinical outcomes and enhance patient safety. NJHA regularly appears before all three branches of government to provide the judiciary and elected and appointed decision-makers with its expertise and viewpoint on issues and controversies involving hospitals and health systems. Fifty-two (52) of NJHA's member hospitals receive DSH funding.

The North Carolina Healthcare Association (NCHA) is a statewide trade association representing 136 hospitals and health systems in North Carolina, with the mission of uniting hospitals, health systems, and care providers for healthier communities. NCHA is an advocate before the legislative bodies, the courts, and administrative agencies on issues of interest to hospitals and health systems and the patients they serve. Eighty (80) of NCHA's member hospitals receive DSH funding.

The Ohio Hospital Association (OHA) is a private non-profit trade association established in 1915 as the first state-level hospital association in the United States. For decades, the OHA has provided a forum for hospitals to come together to pursue health care policy and quality improvement opportunities in the best interest of hospitals and their communities. The OHA is comprised of 237 hospitals and 13 health systems, all located in Ohio, and works with its member hospitals across the state to improve the quality, safety, and affordability of health care for all Ohioans. One hundred twelve (112) of OHA's member hospitals receive DSH funding. The OHA's mission is to collaborate with member hospitals and health systems to ensure a healthy Ohio.

The Hospital and Healthsystem Association of Pennsylvania (HAP) is a statewide membership services organization that advocates for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve. One hundred two (102) of HAP's members receive DSH funding.

The Texas Hospital Association (THA) is a non-profit trade association representing Texas hospitals. THA advocates for legislative, regulatory, and judicial means to obtain accessible, cost-effective, high-quality health care. Two hundred five (205) of the THA's members receive DSH funding.

The Wisconsin Hospital Association (WHA) is a statewide non-profit association with a membership of more than 130 Wisconsin hospitals and health

systems. For nearly 100 years, the Wisconsin Hospital Association has advocated for the ability of its members to lead in the provision of high-quality, affordable, and accessible health care services, resulting in healthier Wisconsin communities. Wisconsin has 44 DSH hospitals.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Amici's member hospitals and health systems serve diverse localities, including rural and urban communities all across the country. They employ millions of health care professionals. And they treat millions of low-income Americans. The services *amici*'s member hospitals provide to our nation's most vulnerable communities often go uncompensated, or are provided at deeply discounted rates. For these reasons, *amici's* members rely on programs established by federal and state governments to assist in providing care to low-income patients. In particular, many of *amici*'s member hospitals rely heavily on Medicare's "Disproportionate Share Hospital" program ("DSH"), which increases Medicare reimbursement rates for hospitals that serve a high-volume of low-income patients.[2]

The importance of the Medicare DSH program cannot be overstated to hospitals and their patients. Many hospitals that serve low-income communities are barely getting by—and indeed, hundreds have either closed in the past decade or are at risk of closing. Losses in government funding, including DSH funding, can force these hospitals to cut off services or close altogether. And when these hospitals close, it can have disastrous consequences, cutting off low-income Americans' access to emergency and primary care, eliminating much-

---

[2] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I) (authorizing DSH adjustment payments).

needed jobs, and contributing to long-term health crises.

Because these hospitals rely on DSH funding, changes to the program, including to its adjustment formula, can have considerable impacts on their bottom line. As the D.C. Circuit has repeatedly observed, the rule at issue in this case itself may have an enormous financial impact on these institutions.[3] Yet, notwithstanding the importance of the program, the effect of changes to it are not always intuitive. For example, questions about whether a new adjustment formula (comprised of a complex set of variables that turn on data from other government programs) will result in greater or lower rates of reimbursement are not easy to answer. Likewise, understanding the consequences of a change on medical care *nationally* often requires careful analysis of the priorities, circumstances, and needs of thousands of *local* communities and hospitals.

The combination of these two factors—the clear importance of the DSH program, coupled with

---

[3] *See Allina Health Servs. v. Price*, 863 F.3d 937, 939 (D.C. Cir. 2017) ("That difference in interpretation makes a huge difference in the real world. Part C enrollees tend to be wealthier than Part A enrollees. Including Part C days in Medicare fractions therefore tends to lead to lower reimbursement rates. Ultimately, hundreds of millions of dollars are at stake for the Government and the hospitals." (citing *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 5 (D.C. Cir. 2011)). The Government initially acknowledged the impact of its rule change in its Petition for Writ of Certiorari. *See* Pet. at 23 ("HHS has informed this Office that the particular issue in this case concerning the proper interpretation of the Medicare-fraction statute alone implicates between $3 and $4 billion in reimbursement for FY2005 through FY2013.").

the uncertainty surrounding the impacts of changes to that program—underscores a key point that *amici* respectfully ask this Court to bear in mind as it considers this case: when it comes to the DSH program, notice-and-comment procedures are an essential component of rulemaking. Without notice-and-comment, the Department of Health and Human Services ("HHS") may fail to fully understand the range of consequences that a rule change will have on hospitals.

Put simply, notice-and-comment is vital to the successful administration of the DSH program. But one would be hard-pressed to understand why that is so from the Government's merits brief. As framed by the Government, the issue before this Court is "the scope of the notice-and-comment rulemaking requirements that the Department of Health and Human Services (HHS) must follow in administering the Medicare Act."[4] The Government barely addresses the DSH program at all, instead asserting that this Court's decision will determine whether HHS must use notice-and-comment in making *any and all* decisions relevant to a "panoply of Medicare contractor guidelines and manuals."[5] Having framed the question this way, the Government asserts that the policy implications of requiring notice-and-comment would be to jeopardize "the flexibility that is essential in light of Medicare's complex and

---

[4] Petitioner's Brief ("PB") at 2.

[5] *Id.* at 21.

frequently changing statutory context and administrative developments."[6]

The Government is wrong, both in its framing and policy analysis. The question before this Court is nowhere near as broad as the Government describes it. It is, more narrowly, whether notice-and-comment was required under the *unique* circumstances of this case: where HHS made a material, substantive, and nationwide change in connection with how it treats Part C patients in calculating the disproportionate patient percentage—and, as Respondents further highlight, where HHS's choice to eschew notice-and-comment in making this change departed from past Agency practice reflecting HHS's own recognition of the importance of notice-and-comment in this context.[7] Contrary to the Government's suggestion,

---

[6] PB at 42 (citing Richard J. Pierce, Jr., *Distinguishing Legislative Rules from Interpretative Rules*, 52 Admin. L. Rev. 547, 550-551 (2000)).

[7] *See* Respondents' Brief ("RB") at 10 ("To implement the DSH payment adjustment, including the determination of days in the DSH fractions, the agency has repeatedly used notice-and-comment rulemaking."). In their merits brief, Respondents further explain the relevance of the unique substantive contours of this rule, as well as the history of its promulgation, to understanding why the Government's policy argument and framing of the question presented are incorrect, and why the D.C. Circuit's holding will not encumber the ability of the Centers for Medicare & Medicaid Services to make non-material administrative changes in the context of the DSH program. *See id.* at 24 (summarizing the several reasons why "[t]he D.C. Circuit's holding will not impose the significant administrative burdens the Government suggests," and will have "virtually no implications outside this case."); *id.* at 54-59; *id.* at 55 ("The Government is also wrong to suggest that affirming the D.C. Circuit's Section 1395hh(a)(2) holding will have wide-ranging negative implications for the operation of Medicare.... Contrary to the Govern-

there are numerous reasons why notice-and-comment is critical *in this particular context*, especially where HHS's rule change may have a monumental effect on the financial viability of DSH hospitals that serve low-income patients. *Amici* thus respectfully submit this brief to provide the Court with important information about how the DSH program impacts its member hospitals and why notice-and-comment procedures are particularly important to material administrative decisions about DSH funding.

---

ment's claim (Br. 42), the publication of binding fractions reflecting a renewed change in national Medicare DSH payment policy has no bearing on the agency's ordinary use of instructions and manual guidance to its contractors.").

ARGUMENT

I. CONGRESS CREATED THE DSH PROGRAM TO ASSIST HOSPITALS IN TREATING LOW-INCOME PATIENTS

A. Congress Created the Medicare DSH Program Both to Reimburse Hospitals for Caring for Low-income Patients, and to Ensure Such Hospitals Survive to Support Their Communities

In the early 1980s, Congress instituted reforms to the reimbursement process under Medicare.[8] In response, certain hospitals expressed concern that the rules—which lowered reimbursement rates—failed to consider the high costs associated with treating large numbers of low-income patients.[9] Responding to these concerns, Congress proposed cost adjustments for hospitals serving low-income communities, initially delegating the job of developing such adjustments to HHS.[10] When, after several years, HHS failed to act, Congress itself stepped in, establishing the DSH payment system in 1986 under the Comprehensive Omnibus Budget

---

[8] *See* Lynne Fagnani and Jennifer Tolbert, *The Dependence of Safety Net Hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Program*, National Association of Public Hospitals & Health Systems, at 3 (Nov. 1999), available at https://collections.nlm.nih.gov /catalog/ nlm:nlmuid-100927939-pdf.

[9] *See id.*

[10] *See id.*

Reconciliation Act (COBRA).[11] The program established criteria for "urban" and "rural" hospitals to qualify for DSH adjustment payments depending on their "disproportionate patient percentage"—a rough approximation for the proportion of care they provide to low-income patients.[12] In particular, it used the sum of two formulas to calculate this percentage: what the District Court in this case referred to as the "Medicare fraction" and the "Medicaid fraction."[13] The Medicare fraction takes the number of patient days for patients entitled to both Medicare Part A and supplemental security income benefits, and divides that number by the number of days for all patients entitled to benefits under Medicare Part A.[14] The Medicaid fraction, in turn, takes the number of patient days for individuals who are eligible for Medicaid but not entitled to benefits under Medicare Part A, and divides it by the total number of patient days.[15]

In creating the DSH program, Congress cited research suggesting two conclusions. *First*, it is more costly to treat low-income patients. Poorer patients

---

[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i); *see also* Disproportionate Share Hospital (DSH), CMS.gov, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html (last accessed Dec. 11, 2018).

[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(v); *see generally* 42 U.S.C. § 1395ww(d)(5)(F).

[13] *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94, 98 (D.D.C. 2016); *see also Allina Health Servs. v. Price*, 863 F.3d 937, 939 (D.C. Cir. 2017).

[14] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

[15] *See id.* at § 1395ww(d)(5)(F)(vi)(II).

seek medical care or intervention only for more severe problems, and thus tend to be sicker than comparable patients.[16] *Second*, hospitals that treat a large percentage of low-income patients tend to incur higher per-patient costs.[17] Given these realities, Congress expressed concern that if hospitals treating such patients did not receive additional financial assistance, they could close—which could have a stark effect on the low-income patients they served and on their communities.[18]

Under the DSH program, qualifying hospitals have received billions in federal funding to offset the costs of caring for low-income patients.[19] These payments, in turn, have been critical to hospitals that treat low-income and uninsured patients, and that,

---

[16] *See* Felicien "Fish" Brown, *Health Policy – DSH Hospitals: Still Caring for the Poor*, Journal of the Catholic Health Association of the United States (Jan-Feb. 1999), available at https://www.chausa.org/publications/health-progress/article/january-february-1999/health-policy-dsh-hospitals-still-caring-for-the-poor (describing Congressional research that motivated the creation of DSH).

[17] *See Brown, supra* note 16.

[18] *See Brown, supra* note 16; *see also* Fagnani, note 8, at 5 ("[T]he purpose of the DSH program has evolved into the much broader one of protecting access to care for low-income patients by supporting the institutions that serve them.").

[19] *See* Fagnani, *supra* note 8, at 5. Medicaid has a separate DSH program, which—in concert with the Medicare DSH program—assists hospitals serving low-income patients through a federal/state partnership. *See Medicaid Disproportionate Share Hospital (DSH) Payments*, Medicaid.gov, https://www.medicaid.gov/medicaid/finance/dsh/index.html (last visited Dec. 11, 2018); Fagnani, *supra* note 8, at 7-11 (describing the history of this program).

without assistance, "have little capacity to recoup their costs ... by charging higher fees."[20]

B. DSH Payments Remain a Necessary Source of Funding for Hospitals Treating Low-income Patients

The DSH program has only grown in importance since it was first created, and it remains vital to assisting hospitals in providing uncompensated care to low-income and uninsured Americans. Such care is more important than ever in preventing long-term health crises, supporting low-income communities, and treating the millions of uninsured Americans who turn to safety net hospitals for services.[21]

---

[20] Michael Spivey & Arthur L. Kellerman, *Rescuing the Safety Net*, 360 New Engl. J. Med. 2598, 2598 (June 18, 2009), available at https://www.nejm.org/doi/10.1056/NEJMp 0900728.

[21] *See* Fagnani, *supra* note 8, at v ("[t]he major sources of" reimbursement "safety net hospitals" receive for uncompensated care come from "Medicare and Medicaid [DSH] programs, along with appropriations from state and local governments"); Caitlin Podbielski, *Piling It on DSH Providers' Plate: Why PPACA's Eyes Are Bigger Than Its Stomach*, 20 Annals Health L. Advance Directive 144, 150–51 (2011) (describing "safety net hospitals" that require federal assistance to reimburse them for uncompensated care); Brown, *supra* note 16 (explaining "safety-net hospitals often treat a high percentage of Medicare and Medicaid patients," and that "Medicare DSH payments are an integral part of the[ir] overall revenue structure"); *id.* ("Catholic hospitals alone received $503 million in Medicare DSH payments last year."); Ariel Hart & Tamar Hallerman, *Grady, Georgia Hospitals Stand to Lose Millions in Federal Payments*, The Atlanta Journal-Constitution, Aug. 5, 2017, available at https://www.myajc.com/news/state-ampampamp-regional/grady-

To illustrate the continued significance of DSH funds, it is helpful to look at two particularly vulnerable categories of hospital (each of which is represented among *amici*'s membership): hospitals that treat low-income rural and urban communities.[22] Rural and urban hospitals are often dependent on DSH funds, and their closure or compelled curtailment of services would have disastrous effects on low-income Americans and their communities.

The rural health crisis is well-documented but often underappreciated. Rural hospitals that serve low-income communities are closing at an alarming rate.[23] These closures often result from a lack of

---

georgia-hospitals-stand-lose-millions-federal-payments/cLZvuPw5flFUuehW1c292H/.

[22] Podbielski, *supra* note 21, at 146 (safety net hospitals "are typically located where the uninsured reside, in depressed rural communities and inner cities"); *accord* Spivey, *supra* note 20, at 2; Brown, *supra* note 16 ("Most DSH hospitals are in urban areas and often the only source of medical care for the poor, who are often uninsured. However, a significant number of these ... institutions exist in rural areas as well.").

[23] *See* Brittany Ruess, *Rural Hospitals on Life Support in Missouri*, Columbia Daily Tribune, Sept. 30, 2017, available at https://www.columbiatribune.com/news/20170930/rural-hospitals-on-life-support-in-missouri (describing a study by the National Rural Health Association that found "673 rural hospitals were at risk of closure and 210 [were] considered to be at an extreme risk for closing"); Jane Wishner, et al, *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*, Kaiser Family Foundation (July 7, 2016), available at https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/ ("The number of rural hospital closures has increased significantly in recent years. This trend is expected to continue, raising questions about the impact the closures will have on rural communities' access to health care services."); Lisa

adequate funding to support low-income patients and a lack of reimbursement for uncompensated care.[24]

The effect of additional losses in funding for rural hospitals—and attendant closures——would be devastating. When rural hospitals close, low-income patients often have to drive long distances for health

---

Rab, *Rural Hospitals Are Dying and Pregnant Women Are Paying the Price*, Politico (Oct. 3, 2017), https://www.politico.com/magazine/story/2017/10/03/meadows-medicaid-rural-hospitals-pregnant-women-dying-215671 (suggesting rural hospitals—to avoid closure—may close expensive units, such as maternity wards); Les Masterson, *Health Affairs: Ending Medicaid Expansion Would Cause Rural Hospitals to go Under*, HeathCareDive.com (Jan. 9, 2018), https://www.healthcaredive.com/news/health-affairs-ending-medicaid-expansion-would-cause-rural-hospitals-to-go/514307/; Michael Ollove, *'Safety Net' Hospitals Face Federal Budget Cuts*, Pew (Jan. 16, 2018), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/01/16/safety-net-hospitals-face-federal-budget-cuts (rural hospitals serving low-income communities "are struggling to keep their doors open"); Debby Warren, *Rural Hospitals Face Growing Financial Trouble, Says Moody's*, Nonprofit Quarterly (Sept. 11, 2018), https://nonprofitquarterly.org/2018/09/11/rural-hospitals-face-growing-financial-trouble-says-moodys/ (noting that the effect of closures could be the loss of 99,000 jobs, and the loss of direct access to care for nearly 12 million patients); Adrienne St. Clair, *Rethinking Rural Health Solutions to Save Patients and Communities*, NPR.org (Feb. 28, 2018), https://www.npr.org/sections/health-shots/2018/02/28/588826085/rethinking-rural-health-solutions-to-save-patients-and-communities.

[24] Wishner, *supra* note 23; Ruess, *supra* note 23 ("Uncompensated care, or care provided the hospital (sic) but not paid for, was largely to blame for the Fulton hospital's poor financial situation. This issue has become all too common for rural hospitals that are located in communities with higher rates of Medicare and Medicaid patients, poverty and people in worse health.").

care, and in the process can lose access to emergency care,[25] primary care,[26] and specialty care.[27] Further, the closure of such institutions can have unforeseen effects that go beyond the provision of medical care. The closure of a hospital can lead to job losses and make it harder for communities to attract new employers,[28] and can cut off other support services a

---

[25] Wishner, et al, *supra* note 23 (noting that in case studies of rural hospital closures, "stakeholders emphasized that a major impact ... was the loss of access to emergency care in the community"); Rab, *supra* note 23 (noting that, for one patient, the closest hospital with a maternity ward was an hour away after her local hospital closed, and citing to studies that indicate that pregnant women who have to travel more than hour to give birth experience more negative medical outcomes); *Key Facts About the Uninsured Population*, Kaiser Family Foundation, at 8 (Dec. 07, 2018), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ ("[S]afety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider").

[26] Wishner, *supra* note 23 ("Because hospital emergency departments are a major source of primary care in rural areas, closures can have a significant impact on access to primary care, but some communities can fill these gaps."); Rab, *supra* note 23 (noting that pregnant women may miss prenatal appointments when long drives—the function of insufficiently close medical institutions—deter them from seeking care).

[27] Wisher, *supra* note 23 (noting that rural communities already faced shortages of specialty care, and that these "difficulties in accessing specialty care increased following the closures"); Health Policy Institute, *Rural and Urban Health, Data Profile Number 7*, Georgetown University (Jan. 2003), available at https://hpi.georgetown.edu/agingsociety/pubhtml/rural/rural.html (describing the physician shortage in rural America, including a severe shortage in mental health professionals).

[28] St. Clair, *supra* note 23 ("For many citizens in small-town America, losing the local hospital would threaten the livelihood

hospital provides to a community beyond direct care.[29]

To be sure, the financial picture for rural hospitals that treat low-income patients is complex. Medicare DSH adjustment payments are not the only source of funds keeping such vulnerable institutions afloat, and a lack of funding is not the only factor contributing to closures. But DSH funds are vital support that can be the difference between financial success and failure.[30] Indeed, the issue is not simply whether such vulnerable institutions will close. Instead, rural hospitals facing cuts in DSH funding face the impossible choices of which services to cut, and more starkly, whether they can continue at all to provide key services to low-income patients and communities—services that are typically unprofitable.[31]

---

of the town and its people"); *accord* Wishner, et al., *supra* note 23; Rab, *supra* note 23.

[29] *See, e.g.*, Wishner, et al., *supra* note 23 (hospital staff had assisted the community by stabilizing individuals with acute mental health and addiction needs and arranging for their transport; when the hospital closed, "local capacity to address these needs disappeared").

[30] *See* Jack O'Brien, *After Individual Mandate Repeal, Who'll Pay for Rise in Uncompensated Care*, *Health*Leaders (Dec. 20, 2017), https://www.healthleadersmedia.com/finance/after-individual-mandate-repeal-who%E2%80%99ll-pay-rise-uncompensated-care (citing a study estimating that 35% of uncompensated care costs are covered by the federal government).

[31] *See* Podbielski, *supra* note 21, at 157-58; Robyn Whipple Diaz, *Unequal Access: The Crisis of Health Care Inequality for Low-Income African-American Residents of the District of Columbia*, 7 J. Health Care L. & Policy 120, 128–29 (2004).

Much like their rural counterparts, hospitals that treat low-income patients in urban communities are similarly dependent on DSH payments—and equally financially vulnerable.[32] In fact, cuts in DSH funding will arguably impact urban hospitals *more*, because those hospitals receive the bulk of Medicare DSH funding as an empirical matter.[33] What is more, closure of such facilities—or curtailment of services

---

[32] *See* Diaz, *supra* note 31, at 121 (discussing the effect of the closure of D.C. General Hospital on the low-income African American community in Southeast D.C.); *see also* David Moyse, *Urban Legend: Dispelling the Myth That Rural Hospitals Require Increased Federal Funding at the Expense of Urban Hospitals*, 22 J. Contemp. Health L. & Policy 210, 217 (2005) ("The greater numbers of low-income, uninsured individuals living in urban areas strain hospitals because the individuals are unable to pay for rendered services"); *id.* at 210 (citing the "severe financial pressures and difficulties" faced by urban hospitals); Ollove, *supra* note 23 (noting that dramatic cuts in DSH funding could impair the New York City Health and Hospitals' ability to treat the 410,000 New Yorkers without health insurance); Debra A. Draper, et al., *Community Report: Financial Pressures Continue to Plague Hospitals*, Health System Change (Summer 2001), available at http://www.hschange.org/CONTENT/359/#jump1 ("Urban hospitals—which constitute the core safety net for low-income, uninsured individuals—have been particularly hard hit by declining patient volume and fewer privately insured patients."); Fagnani, *supra* note 8, at 5, 14, 19, 22 ("Medicare and Medicaid DSH payments have been a vital source of financing for these urban safety net hospitals;" "[w]ithout Medicare DSH payments, the hospitals [analyzed] would have experienced a 10 percent loss on Medicare payments;" and without DSH payments altogether, the "hospitals would have experienced an alarming negative 7 percent margin on total operations in 1996"); Brown, *supra* note 16 ("Medicare DSH payments are an integral part of the overall revenue structure of safety-net hospitals [in urban areas]").

[33] Fagnani, *supra* note 8, at 5.

they might otherwise offer—would have enormous consequences on low-income individuals' access to care.[34] And such closures can also have ripple effects, because urban hospitals often provide ancillary services, including disaster relief programs and even anti-terrorism response plans.[35]

Given the extraordinarily tight margins that DSH hospitals operate under, it should come as no surprise that the reimbursement process is crucial to their success or failure.[36] One study noted, for

---

[34] Diaz, *supra* note 31, at 133 (describing difficulties faced by low-income D.C. residents in accessing primary care after the closure of D.C. General); *id.* at 121 ("Without access to these hospitals, many of D.C.'s poor African-American residents face[d] extremely limited access to health care services ...."); Renee Y. Hsia, et al. ***A US National Study of the Association Between Income and Ambulance Response Time in Cardiac Arrest,*** JAMA Network (Nov. 30, 2018), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2716993 (noting that "[i]n the wake of an increasing number of hospital and emergency department shutdowns, poorer neighborhoods and vulnerable populations have had even less access to care," which, in part, has contributed to an income gap in ambulance response time to a cardiac arrest).

[35] Spivey, *supra* note 20, at 2598 ("In many cities, large safety-net hospitals anchor their region's disaster-response plan. When such hospitals are forced to close or curtail key services, the spillover effects can reach far beyond the uninsured"); Moyse, *supra* note 32, at 219 (describing costly "anti-terrorism measures" implemented by urban hospitals after September 11, 2001).

[36] Fagnani, *supra note* 8, at 5 ("Hospitals that treat large numbers of low-income and uninsured patients often face severe financial difficulties as a result of their mission-related activities. Medicare DSH payments to these hospitals ease their financial burden and help to ensure their continued accessibility to the patients who use them."); Brown, *supra* note 16; Masterson, *su-*

example, that "[w]ithout sufficient DSH payments, the few hospitals that provide significant amounts of uncompensated care face financial crises, further endangering the ability of D.C.'s black poor to access health care services."[37] And as another expert succinctly explained: "even small changes in federal programs can have a disproportionate effect on the financial viability of these hospitals."[38] *Amici*'s members acutely experience those disproportionate effects, including and especially from the rule at issue in this case.

II. NOTICE-AND-COMMENT IS VITAL TO THE SUCCESS OF THE DSH PROGRAM

Given the DSH program's significance, it is especially important for stake-holders to have the opportunity to comment on proposed rules. Hospitals that treat low-income populations, in particular, can provide vital (and often little-known) information to HHS, especially in connection with changes to the DSH reimbursement formula. Allowing for this exchange of information, which is already the

---

pra note 23 ("If Congress eliminated Medicaid expansion without increasing disproportionate share hospital (DSH) payments or other subsidies, more hospitals will close, especially in rural areas"); Craig B. Garner, *Medicare: The Perpetual Balance Between Performance and Preservation*, 30 J. Contemp. Health L. & Policy 279, 283 (2014) (detailing how reforms to Medicare and Medicaid policies have, historically, "raised the threat of catastrophic operating losses for hospitals unable to meet the demands to change"); Diaz, *supra* note 31, at 134.

[37] Diaz, *supra note* 31, at 134.

[38] Warren, *supra* note 23.

agency's regular practice,[39] will help HHS avoid material changes to the DSH program that could have drastic and unforeseen consequences.

The Government gives short shrift to the benefits of notice-and-comment procedures. Those benefits—conspicuously unmentioned in the Government's brief—have been well-articulated in the case-law[40] and the academic literature[41]—including by Professor Richard Pierce, whom the Government cites for the proposition that rule making can be cumbersome.[42]

---

[39] RB at 58 ("[C]ontrary to the Government's suggestion, notice-and-comment rulemaking for Medicare payment standards, including for the DSH payment, is already the norm.").

[40] *See, e.g., Ass'n of Irritated Residents v. EPA*, 494 F.3d 1027, 1043 (D.C. Cir. 2007) ("The legislative history of the APA states that 'due to the unrepresentative nature of an administrative agency, "public participation ... in the rulemaking process is essential in order to permit administrative agencies to inform themselves and to afford safeguards to private interest."'" (quoting *Batterton v. Marshall*, 648 F.2d 694, 704 n.47 (D.C. Cir. 1980)); *Chocolate Mfrs. Ass'n of U.S. v. Block*, 755 F.2d 1098, 1103 (4th Cir. 1985) ("The notice-and-comment procedure encourages public participation in the administrative process and educates the agency, thereby helping to ensure informed agency decisionmaking.").

[41] *See* Jeffrey S. Lubbers, *A Guide to Federal Agency Rulemaking* 123 (5th Ed. 2012) ("[M]ost commentators have espoused the benefits of rulemaking over adjudication for policymaking.").

[42] PB at 42 (citing Pierce, *supra* note 6, 52 Admin. L. Rev. at 550-551); Richard J. Pierce, Jr., 1 *Administrative Law Treatise* 496 (5th Ed. 2010) ("Over the years, commentators, judges, and Justices have shown near unanimity in extolling the virtues of the rulemaking process over the process of making 'rules' through case-by-case adjudication."); *id.* at 496-501 (articulating

The Government quotes Professor Pierce in support of its argument that the "notice-and-comment process can be 'long and costly' and 'often requires many years and tens of thousands of person hours to complete.'"[43] But the Government fails to acknowledge Professor Pierce's immediately preceding discussion of the *benefits* of notice-and-comment procedures:

> The APA rulemaking procedure has many advantages. It enhances the quality of rules by allowing the agency to obtain a better understanding of a proposed rule's potential effects in various circumstances and by allowing the agency to consider alternative rules that might be more effective in furthering the agency's goals or that might have fewer unintended adverse effects. Second, it enhances fairness by providing all potentially affected members of the public an opportunity to participate in the process of shaping the rules that will govern their conduct or protect their interests. Finally, it enhances political accountability by providing the President and members of Congress a better opportunity to influence the rules that agencies issue.[44]

---

nine benefits to rulemaking, including benefits flowing specifically from notice-and-comment).

[43] PB at 42.

[44] Pierce, *supra* note 6, 52 Admin. L. Rev. at 550.

If that were not enough, Professor Pierce's textbook on administrative law specifically draws an example from the Medicare context to illustrate the benefits of notice-and-comment procedures. According to Professor Pierce, a 1990s study detailing inconsistencies in reimbursement rates in Medicare provided "powerful new evidence" of the importance of formal rulemaking in Medicare decision-making.[45]

The general benefits of notice-and-comment rulemaking that Professor Pierce discussed apply with special force to the DSH program. *First*, as Professor Pierce observed, notice-and-comment provides an agency diverse perspectives from numerous stake-holders,[46] educates the agency about the relevant issue, "assure[s] responsive and responsible decisions,"[47] and thus leads to "informed administrative decisionmaking."[48] Indeed, because

---

[45] *See Pierce, supra* note 42, *Administrative Law Treatise* at 501 (citing a GAO study indicating that a lack of rulemaking had resulted in major interregional inconsistences in reimbursement grant and denial rates as "powerful new evidence concerning the value of agency rules").

[46] Pierce, *supra* note 42, *Administrative Law Treatise* at 497; Att'y Gen.'s Comm. on Admin. Procedure, Administrative Procedure in Government Agencies, S. Doc. No. 77-8, at 101-02 (1st Sess. 1941) ("An agency's deliberations are not carried on in public and its members are not subject to direct political controls as are legislators ... [I]ts knowledge is rarely complete, and it must always learn the frequently clashing viewpoints of those whom its regulation will affect.").

[47] Glen O. Robinson & Ernest Gellhorn, *The Administrative Process* 809 (1974).

[48] *Ass'n of Irritated Residents*, 494 F.3d at 1043 ("[P]ublic participation assures that the agency will have before it the facts and information relevant to a particular administrative problem ...

notice-and-comment assists an agency in gathering information about a rule, many commentators, including Pierce, have cited its *efficiency* (notwithstanding the Government's suggestion that such rulemaking is inherently cumbersome).[49]

This kind of informed decision-making is especially valuable to the success of the DSH program. Hospitals treating low-income patients are not all the same. They face diverse problems, all of which can be relevant to the effect a change in DSH rules would have on their ability to serve low-income

---

[and] increas[es] the likelihood of administrative responsiveness to the needs and concerns of those affected." (quoting *Am. Hosp. Ass'n v. Bowen*, 834 F.2d 1037, 1061 (D.C. Cir. 1987)); Lubbers, *supra* note 41, at 257; Pierce, *supra* note 6, 52 Admin. L. Rev. at 550 (Rulemaking "enhances the quality of rules by allowing the agency to obtain a better understanding of a proposed rule's potential effects in various circumstances and by allowing the agency to consider alternative rules that might be more effective in furthering the agency's goals or that might have fewer unintended adverse effects"); Eugene Scalia, *The Value of Public Participation in Rulemaking*, The Regulatory Review (Sept. 25, 2017), available at https://www.theregreview.org/2017/09/25/scalia-public-participation-rulemaking/ ("We value public participation in rulemakings in part because it is an opportunity to bring valuable evidence to the agency's attention, to explain effects of a proposed rule that the agency may not have appreciated, and simply to bring a perspective that the agency itself otherwise would not have.").

[49] Richard K. Berg, *Re-examining Policy Procedures: The Choice between Rulemaking and Adjudication*, 38 Admin. L. Rev. 149, 163 (1986) ("Such broader participation" through notice-and-comment "also makes rulemaking more efficient as an information-gathering technique for the agency"); Pierce, *supra* note 42, *Administrative Law Treatise* at 497.

patients.[50] It is impossible for HHS to predict the effect of a change on all of these stake-holders without consulting them. Hospitals, further, are better positioned to articulate the effect of a rule change on their ability to provide care.[51] They also will be able to identify far-reaching, but potentially unexpected, consequences to funding changes,[52] and provide up-to-date information about their industry that may illuminate the challenges they are facing and assist HHS in formulating a rule that better accomplishes the purpose of the program itself.[53]

---

[50] *See, e.g.*, Moyse, *supra* note 32, at 212 (arguing HHS failed to consider unique needs of urban hospitals, and the financial impact upon them, in changing key rules); Diaz, *supra* note 31, at 133-34 (describing the specific needs of D.C. General—and the specific circumstances that made it unique from other hospitals, and contributed to its closure, including the fact that its uncompensated care costs were astronomical); Wishner, *supra* note 23 (analyzing three rural hospitals, and discussing with local thought leaders the particular reasons these hospitals were imperiled).

[51] *See, e.g.*, Ollove, *supra* note 23 (noting that funding cuts of less than a million dollars to a local Tennessee hospital (the largest employer in its community) could require cutting back on services, and possibly lead to the hospital's closure); *see id.* ("Other hospitals mentioned the possibility of cutting back on the number of social workers, follow-ups with patients after discharge, and transportation services to help poor patients get to medical appointments.").

[52] *See, e.g.*, Moyse, *supra*, note 32, at 218-19 (noting that hospitals have formulated emergency-response plans to respond to "biological or chemical weapon attacks"); *see also infra* notes 28-29, 35 and accompanying text (discussing potential impacts of hospital closures on communities beyond access to health care).

[53] Draper, *supra* note 32 (explaining how changes in health plans' inpatient utilization management efforts have affected hospital revenues); Fagnani, *supra* note 8, at vi (noting that

Second, as Professor Pierce stated, notice-and-comment allows "all potentially affected members of the public an opportunity to participate in the process of shaping the rules that will govern their conduct and protect their interests."[54]

This principle is again particularly important in the DSH context. Hospitals across the country face enormous challenges, and their ability to stay open in the face of a shifting health care landscape and funding cuts often turns on the herculean efforts of care-givers.[55] These hospitals face pressures to cut back on the very services the DSH program is

---

DSH changes would be particularly problematic in light of "local government appropriations," "market forces," and an "eroding Medicaid patient base"); *id.* (explaining that new technologies have made medical care more outpatient-focused, rather than in-patient focused, and criticizing the DSH qualifying formula for failing to consider this industry trend); Brown, *supra* note 16 (explaining how changes to commercial insurers' reimbursement rates will make Medicare DSH payments all the more significant—and that without those payments, market forces will push hospitals to "reduce their commitment to serving the poor"); *see also* Lubbers, *supra* note 41, at 271-72 ("[T]here is little question that agencies must and do take comments seriously and often modify the final rule as a result of them").

[54] Pierce, *supra* note 6, 52 Admin. L. Rev. at 550; Lubbers, *supra* note 41, at 123 ("A rule formulated after rulemaking ... is fairer to the class of persons who would be affected by [it] than a rule announced in an adjudication" (internal quotation marks omitted)); Robinson and Gellhorn, *supra* note 47, at 809 (notice-and-comment "can serve as a safety valve allowing interested persons and groups to express their views before policies are announced and implemented").

[55] *See, e.g.*, Ollove, *supra* note 23 (interviewing the CEO of a local Tennessee hospital, who detailed his efforts to keep the hospital afloat in the face of budget cuts).

designed to help them provide: unprofitable services to low-income Americans.[56] Including these hospitals in the process of creating the rules that govern their ability to provide that care is not just important to ensuring the best rules are adopted. It is also critical to ensuring such hospitals are treated as partners in the program's overarching mission.

What is more, DSH hospitals can more effectively serve as the voices for the patients they serve, who are most directly impacted by material changes in DSH funding. Those low-income patients, however, are likely to be unfamiliar with the administrative process and therefore unable to share their perspectives on these vital issues. Notice-and-comment can ensure the hospitals, and their patients who are directly affected by the policy and changes to it, have a say in the administrative rule-making process.

If the importance of notice-and-comment to the DSH program is not already clear, this case illustrates it in spades. The Government's merits brief, for example, noticeably elides the question whether its new rule would *in fact* result in greater or lower reimbursement rates. The Government explains that "[i]f, as the court of appeals assumed,

---

[56] *See, e.g.*, Diaz, *supra* note 31, at 128-29 ("Provision of services to those without adequate medical insurance is unattractive to health care providers, and may cause hospitals and individual physicians to terminate or severely limit services to the uninsured."); Podbielski, *supra* note 21, at 147 ("Tax-exempt hospitals, specifically, have historically offered some of these services to eligible individuals free of charge as charity care, but in an era of negative operating budgets, charity care has become a controversial and arguably waning practice.").

'Part C enrollees [are] wealthier than Part A enrollees,' the inclusion of Part C Patients in the Medicare fraction would—if the assumption is true—tend to reduce the value of the fraction (and thus possibly reduce the amount of respondents' 'additional payment.')"[57] The Government then attempts to undercut this assumption—casting doubt through citation to "research" that has "shown that Part C enrollees tend to have lower incomes at similar rates as Medicare beneficiaries who are not enrolled in Part C."[58] The purpose of the sentences may be to suggest to this Court that the Government's rule change is not particularly significant—a position the Government itself has previously contradicted.[59] But HHS's own lack of clarity about the impact of its rule is telling in a different way. The question before this Court is *not* whether the rule change, in fact, will dramatically lower the adjustment rates for hospitals serving low-income patients, as the D.C. Circuit suggested it would.[60] Instead, the question is what process should

---

[57] PB at 4 (citation omitted).

[58] *Id.* at 4-5

[59] In contrast to its merits brief, which implies to the Court that the rule change at issue here would *not* have a major financial impact on hospitals, the Government previously represented to this Court that the rule *would* have a major financial impact—in seeking review. Pet. at 23 ("HHS has informed this Office that the particular issue in this case concerning the proper interpretation of the Medicare-fraction statute alone implicates between $3 and $4 billion in reimbursement for FY2005 through FY2013.").

[60] *Allina Health Servs.*, 863 F.3d at 939. The question of how much this very rule will cost was also the key issue when HHS previously attempted to promulgate this same rule in 2004. The Agency first proposed to interpret the DSH formula consistent

be employed to ensure that the Agency, in making a new rule, knows the answer to significant questions and has worked with diverse stake-holders to understand the consequences of its rule.[61]

Put another way, notice-and-comment does not promise an outcome. But it does provide a process for ensuring that the government receives relevant information before making consequential administrative decisions. That process is especially important where, as here, modest changes to the

---

with its past practice, and not consider patients enrolled in Medicare Part C as part of the Medicare fraction. *See Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1106 (D.C. Cir. 2014); *see also* RB at 11-15 (detailing the history of the notice, adoption, and challenges to the 2004 rule). In doing so, it indicated that the rule would have no major "financial impact," and received only 26 comments. *See id.* It then adopted the opposite interpretation—which resulted in tens of millions of dollars less in adjustment payments per year. *Allina*, 746 F.3d at 1107. The Agency's failure to announce the *actual* rule change it was contemplating failed, in turn, to generate the very comments which would have flagged this enormous financial impact—and likely challenged the rule. And, indeed, the D.C. Circuit held that the rule ultimately promulgated was not a logical outgrowth of the rule announced *precisely* because of the enormous distinction in cost. *See Allina*, 746 F.3d at 1109. In short, the Agency has long waffled on the precise cost of this rule—and long avoided properly using a notice-and-comment procedure that could have provided a meaningful forum to actually address this cost and its impact. *See generally* RB at 11-15.

[61] *See* Pierce, *supra* note 42, *Administrative Law Treatise* at 499 (Through notice–and-comment "valuable comments will go far beyond lawyers' arguments" and "will include studies and affidavits of experts in a variety of fields supporting the agency's views, contradicting its views, criticizing the agency's studies, and proposing more effective or less intrusive alternatives to the agency's proposal").

DSH program will have outsized effects on our most vulnerable citizens, and where, as here, input from stake-holders can fill glaring gaps in agency knowledge.

CONCLUSION

The Medicare DSH program is a vital lifeline for hospitals serving low-income, vulnerable communities. Changes to that program can have enormous and unexpected effects on these hospitals. Notice-and-comment procedures can ensure that those changes are implemented after agency consultation with diverse stake-holders, which can help prevent mistakes that could have dramatic and irreversible consequences on the patients and communities these hospitals serve. *Amici* respectfully submit that the Court should be mindful of these consequences, this DSH context, and the benefits of notice-and-comment as it evaluates the legal issues in this case.

Respectfully submitted,

CHAD I. GOLDER
Counsel of Record
MUNGER, TOLLES & OLSON LLP
1155 F Street NW, 7th Floor
Washington, DC 20004
(202) 220-1107
chad.golder@mto.com

J. MAX ROSEN
MUNGER, TOLLES & OLSON LLP
560 Mission Street, 7th Floor
San Francisco, CA 94105
(415) 512-4000
max.rosen@mto.com

December 20, 2018